DARROCH BRAIN AND SPINE INSTITUTE OF DOCTORS MEDICAL CENTER
4016 DALE RD. MODESTO, CA 95356
PHONE (209) 571-0288

## PATIENT INFORMATION

| NAME (Last, First, Middle) | BIRTHDATE (MM/DD/YYYY) | AGE | SEX | MARITAL STATUS |
|---|---|---|---|---|
| | | | | |

| MAILING ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| HOME PHONE | CELL PHONE | ALTERNATE PHONE |
|---|---|---|
| ( ) | ( ) | ( ) |

| SOCIAL SECURITY NUMBER | E-MAIL ADDRESS | EMERGENCY CONTACT NAME / PHONE NUMBER |
|---|---|---|
| | | |

## REFERRING PHYSICIAN

| REFERRING DOCTOR NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| | | ( ) |

| PRIMARY CARE PHYSICIAN NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| | | ( ) |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | ID/POLICY# | GROUP # |
|---|---|---|
| | | |

| SUBSCRIBER NAME | RELATIONSHIP | SUBSCRIBERS EMPLOYER |
|---|---|---|
| | | |

| SUBSCRIBERS SOCIAL SECURITY NUMBER | SUBSCRIBERS DATE OF BIRTH | CO-PAY AMT |
|---|---|---|
| | | $ |

## SECONDARY INSURANCE (IF APPLICABLE)

| NAME OF INSURANCE COMPANY | ID/POLICY# | GROUP# |
|---|---|---|
| | | |

| SUBSCRIBERS NAME | RELATIONSHIP | SUBSCRIBERS EMPLOYER |
|---|---|---|
| | | |

| SUBSCRIBERS SOCIAL SECURITY NUMBER | SUBSCRIBERS DATE OF BIRTH | CO-PAY AMT |
|---|---|---|
| | | $ |

## WORKERS COMPENSATION INFORMATION

| WORK COMP CARRIER NAME | CARRIER'S ADDRESS |
|---|---|
| | |

| CLAIM # | DATE OF INJURY | EMPLOYER AT TIME OF INJURY |
|---|---|---|
| | | |

| ADJUSTER'S NAME | ADJUSTER'S PHONE NUMBER | ADJUSTER'S FAX NUMBER |
|---|---|---|
| | | |

I hereby consent to allow, use, disclose and furnish photocopies of my records to insurance companies, physicians, hospitals, medical equipment/supply companies, physical therapists as needed for my medical care and to use information for purposes related to treatment, payment or healthcare operations. I understand that I am ultimately responsible for payment of all charges incurred in this office regardless of coverage. This authorization is valid until revoked. The above information furnished by me is true and accurate to the best of my knowledge.

PATIENT SIGNATURE:_____ DATE:_____

DARROCH BRAIN & SPINE INSTITUTE OF DOCTORS MEDICAL CENTER

**PLEASE COMPLETE THIS MEDICAL QUESTIONNAIRE TO THE BEST OF YOUR KNOWLEDGE**

PATIENT NAME:_____ DATE:_____

DATE OF BIRTH:_____ AGE:_____ SEX: □ Male □ Female

**CURRENT CHIEF COMPLAINT:**

Main complaint or reason for consultation:_____

_____

_____

When did your pain start?:_____ The pain began: □ Suddenly □ Gradually □ Chronic

Did the symptoms arise as a result of an injury? □ Yes □No If yes, date of injury?:_____

If you were injured, is the injury related to: □ Job/Industrial □ Motor Vehicle Accident □ Other:_____

**TREATMENT YOU HAVE RECEIVED TO DATE:**

□ Physical Therapy How long?:_____ Did it help?_____

□ Chiropractic Treatment How long?_____ Did it help?_____

□ Medications: Name of medications_____
_____Did they help?_____

□ Injection Therapy:
- □ Epidural injection: When?_____How many?_____ Did it help?:_____
- □ Facet blocks: When?_____How many?_____ Did it help?:_____
- □ Trigger points: When?_____How many?_____ Did it help?:_____
- □ Other:_____When?_____ Did it help?:_____

Have you ever had any of these tests:
- □ MRI of the brain or spine: When?:_____
- □ CT scan of the brain or spine: When?:_____
- □ Myelogram: When?:_____
- □ EMG/NCV: When?:_____
- □ EEG: When?:_____
- □ X-rays: When?:_____

**MEDICAL HISTORY:**

**CURRENT MEDICAL PROBLEMS: (check all that apply)**

| | | | |
|---|---|---|---|
| □ AIDS/HIV | □ Diabetes - Type or Type II | □ Hypertension | □ Pancreatitis |
| □ Arthritis/Gout | □ Depression | □ Irregular Heartbeat | □ Seizures |
| □ Asthma | □ Emphysema/COPD | □ Liver or Kidney Problems | □ Stroke |
| □ Bleeding Condition | □ Glaucoma | □ Neuropathy | □ Thyroid Disease |
| □ Blood clots / DVT | □ Heart Disease/Heart attack | □ Osteoporosis | □ Ulcers or Reflux |
| □ Cancer: | □ Hepatitis | □ Pacemaker or Heart Valve | □ Other:_____ |

Type/location:_____

**SURGICAL HISTORY: (please list all surgeries and dates)**

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Other illnesses requiring hospitalization: (include dates)

1._____ 4._____
2._____ 5._____
3._____ 6._____

**MEDICATIONS YOU ARE CURRENTLY TAKING: (please include dosage, supplements and over the counter drugs and why you are taking them)**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Do you have any medication allergies? □ Yes □ No
If yes, please list allergies:_____

Are you allergic to ADHESIVE TAPE? □ Yes □ No Are you allergic to LATEX? □ Yes □ No
Are you allergic to IODINE? □ Yes □ No Are you allergic to Gadolinium? □ Yes □ No

Pharmacy Name:_____ Phone number:_____

Pharmacy Address:_____

**FAMILY HISTORY:**

Place of Birth:_____ Language:_____

Race:_____ Ethnicity:_____ Religion (optional):_____

Do you live with your spouse? □ Yes □ No □ Not applicable

Do you have children? □ Yes □ No
If yes, please list:

| CHILDREN: | AGE | HEALTH |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do any blood relatives have the following major health problems? If yes, who?

□ Asthma_____ □ Diabetes_____ □ Hypertension_____
□ Blood vessel disease_____ □ Heart disease_____ □ Psychological disorder_____
□ Cancer: Type:_____ □ Other:_____

Are there any hereditary diseases in your family that you are aware of? □ Yes □ No
If yes, please list:_____

**SOCIAL HISTORY:**

Marital Status: □ Married □ Separated □ Divorced □ Single □ Widowed

Tobacco Use: □ None □ Current Smoker: _____ pack(s) per day □ Chewing Tobacco □ Cigars
□ Previous Smoker: when did you quit?_____

Alcohol Use: □ None □ Occasional / Social □ Daily

Occupation:_____ Employer:_____

Length of Employment:_____ Current Work Status: □ Regular Work □ Light Duty □ Off Work

Are you pregnant? □ Yes □ No Is it possible that you could be pregnant?_____

Height:_____ Weight:_____ What is the most you have ever weighed?_____

**REVIEW OF SYSTEMS: (please check yes or no if you have had these in the last 6 months)**

| | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|
| **Constitutional:** | Recurrent fevers | | | Fatigue | | | Weight Loss / Gain | | |
| **Skin:** | Rash | | | Ulceration | | | Excessive Dryness | | |
| **Hematologic:** | Bruising | | | Easy bleeding | | | Swollen Glands | | |
| **Endocrine:** | Tremors | | | Hair Loss | | | Generalized Weakness | | |
| **Eyes:** | Blurry | | | Dry Eyes | | | Excess Tearing | | |
| **ENT:** | Ringing Ears | | | Bloody noses | | | Trouble Swallowing | | |
| **Cardio:** | Chest Pain | | | Racing Heart | | | Leg Swelling | | |
| **Respiratory:** | Coughing | | | Congestion | | | Shortness of Breath | | |
| **GI:** | Tarry Stools | | | Bloody stools | | | Abdominal Pain | | |
| **Urinary:** | Frequency | | | Blood in Urine | | | Burning with Urination | | |
| **Allergic/Immunologic:** | Asthma | | | Hives | | | Hay Fever | | |
| **Musculoskeletal:** | Muscle Pain | | | Joint Pain | | | Joint Swelling | | |
| **Neurological:** | Dizziness | | | Facial pain | | | Headaches | | |
| **Psychiatric:** | Depression | | | Anxiety | | | Mood Swings | | |

**PAIN ASSESSMENT:**

What kind of pain do you have: □ Sharp □ Aching □ Dull □ Throbbing □ Other:_____

Is the pain always there, or does it come and go?_____

Do you have weakness in your arms / legs? □ Yes □ No If yes, when did it start?_____

Do you have numbness or tingling in your arms / legs? □ Yes □ No If yes, when did it start?_____

Have you had trouble controlling your bowels /bladder? □ Yes □ No If yes, when did it start?_____

What makes the pain better / worse?

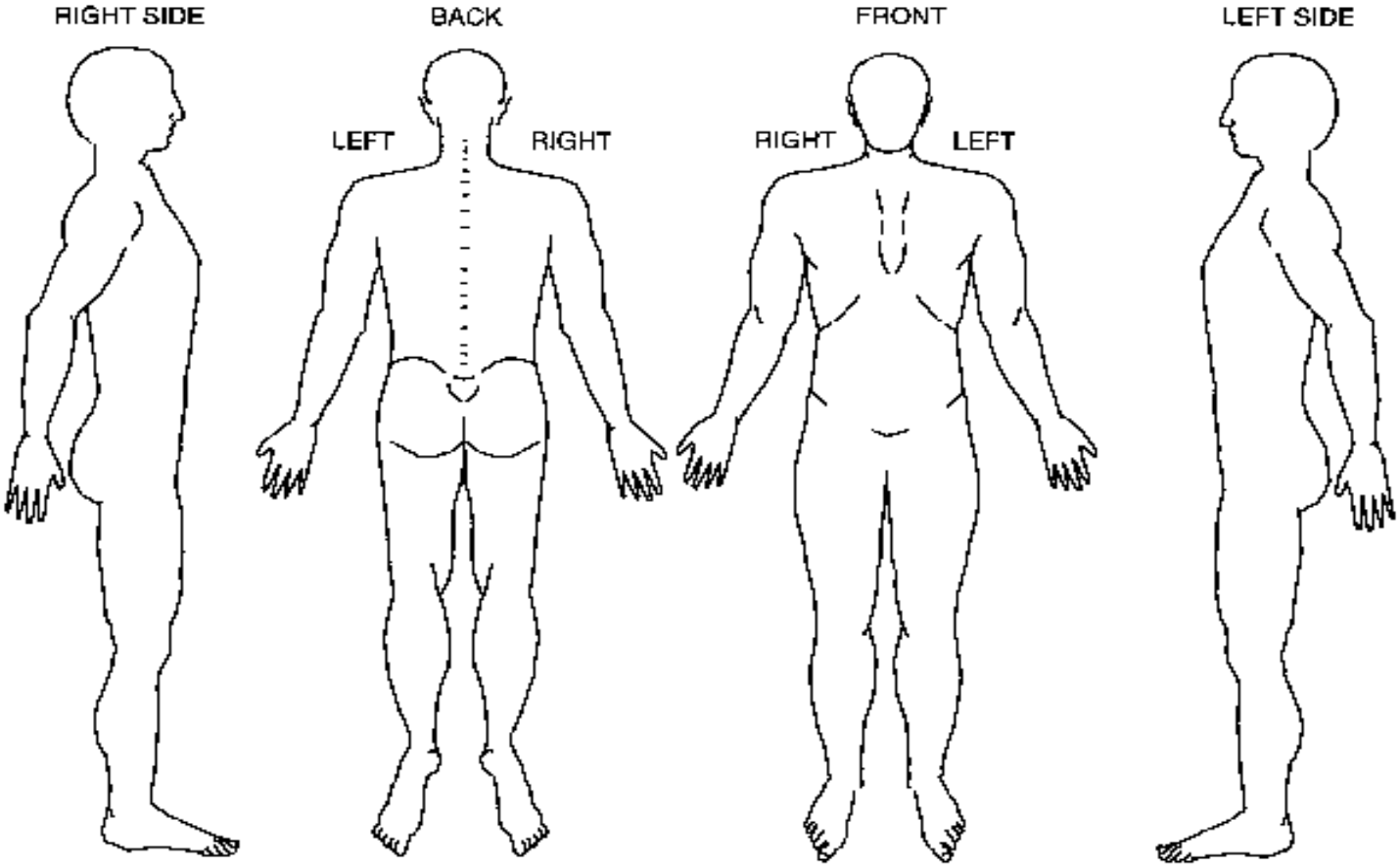
| | | | |
|---|---|---|---|
| Walking: | □ Better | □ Worse | □ No difference |
| Standing: | □ Better | □ Worse | □ No difference |
| Sitting: | □ Better | □ Worse | □ No difference |
| Lying down: | □ Better | □ Worse | □ No difference |
| Bending: | □ Better | □ Worse | □ No difference |
| Driving: | □ Better | □ Worse | □ No difference |
| Coughing/ Sneezing: | □ Better | □ Worse | □ No difference |

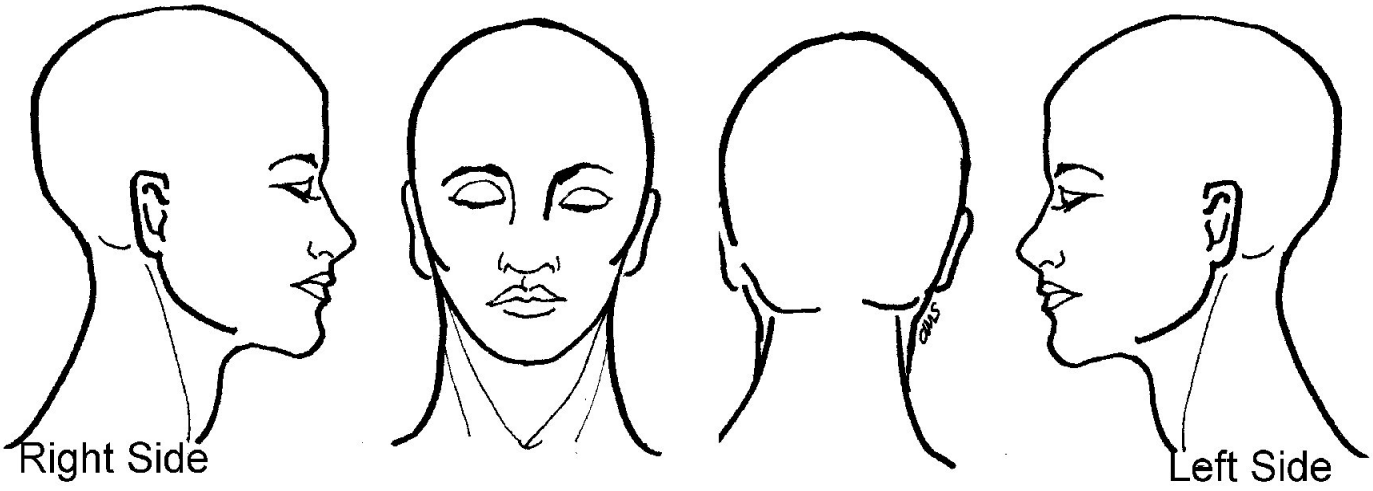
How long can you sit with no/minimal pain:_____

How long can you stand with no/minimal pain:_____

How long can you walk with no/minimal pain:_____

**PLEASE OUTLINE THE AREAS ON YOUR BODY WHERE YOU FEEL YOUR SYMPTOMS:**




**PLEASE CIRCLE THE NUMBER BELOW THAT DESCRIBES YOUR CURRENT PAIN:**

**NO PAIN 0 1 2 3 4 5 6 7 8 9 10 THE WORST PAIN YOU HAVE EVER HAD**

Thank you for completing this form. Please bring it with you to your appointment.